APPLICATION FOR REIMBURSEMENT FROM THE MEDICAL BENEFITS FUND

Michigan Department of Consumer & Industry Services
Bureau of Workers' & Unemployment Compensation
P O Box 30016, Lansing, MI 48909

Authority: Workers' Disability Compensation Act 418.862(2). Completion of this form is voluntary.

Type or print clearly. Incomplete applications shall be returned.

Employee Name (Last, First, MI)			Social Security Number		
Address (Street Number and Name)			Date of Injury	Date of Birth	
City			State	Zip Code	
Employer Name			Insurance Carrier or Service Company		
Address (Street Number and Name)			Address (Street Number and Name)		
City	State	Zip Code	City	State	Zip Code
Federal ID Number			NAIC or Self-Insurance Number		

Is there a health carrier covering this employee? ☐ Yes ☐ No

If yes, please indicate the name of that carrier :

Please state the reason these bills have not been submitted to the health carrier for payment:

Period covered by this request

FROM			THROUGH		
Month	Day	Year	Month	Day	Year

A COPY OF THE MAGISTRATE'S ORDER AND ALL SUBSEQUENT APPELLATE ORDERS MUST ACCOMPANY THIS REQUEST.

Total Reimbursement Amount Requested

$

A COPY OF ALL ORIGINAL INVOICES (INCLUDING DATE OF SERVICE, NAME OF THE HEALTH CARE PROVIDER AND DIAGNOSIS) AND PROOF OF PAYMENT SHOWING AMOUNT AND DATE PAID MUST BE ATTACHED TO THIS REQUEST.

Before you sign this request for reimbursement,
please be sure all attachments are included and the form is complete.

Name of Authorized Representative (Please print)	Title	Date
Signature of Authorized Representative	Telephone Number (Include area code)	

BWC-271 (2-98)
Internet Form

The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.